

Waiver of Electronic Requirement - 2015 Annual Survey of Income and Expense



NASSAU COUNTY DEPARTMENT OF ASSESSMENT
240 OLD COUNTRY ROAD, 4TH FLOOR
MINEOLA, NY 11501

ASIE-2015
ASSISTED LIVING/NURSING HOME
ANNUAL SURVEY OF
INCOME AND EXPENSE

SECTION A - PROPERTY IDENTIFICATION

1	LIST ONLY THE PRIMARY SECTION, BLOCK & LOT <table style="width: 100%;"> <tr> <th style="width: 33%;">SECTION</th> <th style="width: 33%;">BLOCK</th> <th style="width: 33%;">LOT</th> </tr> <tr> <td style="height: 30px;"></td> <td style="height: 30px;"></td> <td style="height: 30px;"></td> </tr> </table>	SECTION	BLOCK	LOT				OFFICE USE ONLY
SECTION	BLOCK	LOT						
2	Property Address Street Address: _____ City, State, Zip: _____							
3	Mailing Address Correction - Only if you wish to change address on letter. Street Address: _____ City, State, Zip: _____							

SECTION B - CONTACT INFORMATION

4	OWNER'S NAME	5	ORGANIZATION
6	CONTACT'S NAME	7	CONTACT'S RELATION TO PROPERTY
8	CONTACT'S E-MAIL ADDRESS	9	CONTACT'S PHONE

SECTION C - CONTIGUOUS LOTS

YOU MAY CONSOLIDATE YOUR FILING BELOW FOR PROPERTIES THAT ARE PHYSICALLY CONTIGUOUS AND/OR ADJACENT ONLY. THESE MUST BE COMMONLY OWNED AND OPERATED. ANY FILING WHICH DOES NOT MEET THESE PARAMETERS WILL BE CONSIDERED NON-COMPLIANT.

10	SECTION	BLOCK	LOT	SECTION	BLOCK	LOT

SECTION D - PROPERTY DESCRIPTION AND USE

11	NAME OF ASSISTED LIVING OR NURSING HOME FACILITY:	ASSISTED LIVING OR NURSING HOME VACANCY IN 2015
FOR ASSISTED LIVING ONLY		
12	TOTAL NUMBER OF ASSISTED LIVING RESIDENTS	TOTAL NUMBER SHARED ROOMS OR SUITES
13		
14	TOTAL NUMBER OF STUDIOS	TOTAL NUMBER OF 1-BEDROOMS
15		
16	TOTAL NUMBER OF 2-BEDROOMS	
FOR NURSING HOMES ONLY		
17	TOTAL NUMBER OF NURSING HOME BEDS	TOTAL NUMBER OF ROOMS
18		
19	NUMBER OF BED DAYS MEDICARE/MEDICAID CLIENTS	NUMBER OF BED DAYS SELF-PAY CLIENTS
20		
21	NUMBER OF BED DAYS INSURANCE PAY CLIENTS	

IF THIS FILING IS FOR A NURSING HOME, COMPLETE SECTION E BELOW, THEN REPORT EXPENSES IN SECTION G ON THE REVERSE OF THIS FORM AND SIGN CERTIFICATION IN SECTION G TO COMPLETE YOUR FILING

SECTION E - NURSING HOME OPERATING INCOME

22	MEDICARE/MEDICAID INCOME FOR CLIENTS	2015 GROSS RECEIPTS (\$)
		\$
23	SELF PAY	\$
24	INSURANCE PAY	\$
25	OTHER INCOME (DETAIL IN NOTES)	\$
26	TOTAL NURSING HOME INCOME ADD LINES 22 THRU 25	\$

NOTES:

IF THIS FILING IS FOR AN ASSISTED LIVING, COMPLETE SECTION E BELOW, REPORT EXPENSES IN SECTION F AND SIGN CERTIFICATION IN SECTION G TO COMPLETE YOUR FILING

SECTION F - ASSISTED LIVING OPERATING INCOME		2015 GROSS INCOME (\$)
27	ASSISTED LIVING FACILITY	\$
28	GROUND RENT	\$
29	OTHER INCOME (DETAIL IN NOTES)	\$
30	OWNER OCCUPIED (DETAIL IN NOTES)	\$
31	SERVICES	\$
32	R E TAX ESCALATION	\$
33	OPERATING ESCALATION	\$
34	SALE OF UTILITIES	\$
35	CELL TOWERS / ANTENNA	\$
36	TOTAL GROSS RENTAL INCOME	\$
ADD LINES 27 THROUGH 35		

NOTES:

ENTER ASSISTED LIVING OR NURSING HOME EXPENSES FOR APPLICABLE ITEMS ONLY

SECTION G - OPERATING EXPENSES NURSING HOME OR ASSISTED LIVING		2015 EXPENSES
37	FIXED OR MINIMUM RENT	\$
38	PERCENTAGE RENT	\$
39	REAL ESTATE TAXES PAID BY LESSEE	\$
40	COMMON AREA MAINTENANCE (EXCLUDING TAXES AND INTEREST)	\$
41	MANAGEMENT PAYROLL	\$
42	OFFICE PAYROLL	\$
43	BUSINESS PAYROLL	\$
44	PAYROLL TAX AND BENEFITS	\$
45	FUEL	\$
46	ELECTRICITY	\$
47	WATER & SEWER	\$
48	PROPERTY INSURANCE	\$
49	PERSONAL INSURANCE	\$
50	MANAGEMENT (EXCLUDING MANAGEMENT PAYROLL)	\$
51	REPAIRS AND MAINTENANCE TO REAL PROPERTY	\$
52	LEASING COMMISSION	\$
53	BUSINESS TAX	\$
54	OFFICE EXPENSE	\$
55	MISCELLANEOUS CHARGES	\$
56	TOTAL OPERATING EXPENSES	\$
ADD LINES 37-55		
57	OTHER EXPENSES (DETAIL IN NOTES)	\$
58	TOTAL EXPENSES	\$
ADD LINES 56 AND 57		

NOTES:

SECTION H - CERTIFICATION (MANDATORY)

☐ I hereby certify that I am the owner or other person responsible for the payment of taxes, or the person authorized by the owner or taxpayer to make this statement. I certify that all information contained in the statement is true and correct to the best of my knowledge and belief. I understand that the willful making of any false statement of material fact herein will subject me to the provisions of the penal law relevant to the making and filling of false instruments. I understand that the willful making of any false statement of material fact herein will also deem this filing untimely.

Name of individual certifying this statement _____

The individual certifying is: ☐ The applicant ☐ Authorized representative listed in Part C ☐ Member or manager of applicant LLC ☐ General partner of applicant ☐ Officer of corporate applicant ☐ Qualified fiduciary ☐ Officer of condominium association ☐ Officer of applicant's corporate member or partner

(name of corporation: _____)

SIGNATURE

PRINT NAME

DATE